MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

CERTIFICATE OF DEATH

02492

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lavina E. C. Airing

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Airing

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 21, 1861

8. AGE: Years	Months	Days	If less than one day
84	2	20	hrs. min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER 12. Name: Jacob Hess

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Elizabeth Jones

MOTHER 15. Birthplace: Penna.

16. Informant: Mrs. Zieber Stultz

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 15, 1946 (month) (day) (year)

Cemetery or crematory: Reformed Cemetery

Location: Taneytown, Md.

18. Funeral director: C.O. Fuss & Son

Address: Taneytown, Md.

19. March 15 1946 (Date rec'd by registrar) Ethel M. Melring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 12 1946, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 2 1946, to Mar 12 1946 and that I last saw h alive on Mar 12 1946

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 3-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02493 Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Bird Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 64 years 15 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Bird Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. 6 Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gertrude Geneva Baker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: John W. Baker
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): March 12, 1882

8. AGE: Years	Months	Days	If less than one day
64	0	15	hrs. min.

9. Birthplace: Bird Hill (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Joseph H. Shipley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Alice Shipley
15. Birthplace: Maryland

16. Informant: John W. Baker
Address: Bird Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 30, 1946 (month) (day) (year)
Cemetery or crematory: Deer Park
Location: Smallwood, Maryland
18. Funeral director: J. Francis Reese
Address: Westminster, Maryland
19. 3/29/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 19 46, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 44 to March 27 19 46 and that I last saw h.er alive on March 26 19 46

Immediate cause of death	DURATION
Lobar Pneumonia	1 wk.
Due to Carcinoma, left Breast Cachexia	2½ yrs.
Due to Secondary Anemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Ca L. Breast 1944
Date of op. 1944
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher, M. D. or other
Address: Westminster Md. Date signed 3/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

02494

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH
County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Amos Calvin Bacheoar

3. (b) Social Security Number: 213-20-9838

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lulu Kate Bacheoar
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): March 10 - 1868

8. AGE: Years	Months	Days	If less than one day
78	0	13	hrs. min.

9. Birthplace: Littlestown Pa.
(Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business:

FATHER
12. Name: Amos Bacheoar
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Catherine Matilda Shealey
15. Birthplace: Pennsylvania

16. Informant: Dr C. M. Benner
Address: Taneytown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 26, 1946 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Gettysburg, Pa.

18. Funeral director: C.O. FUSS & SON
Address: Taneytown, Md.

19. March 23 1946 Ethel M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh Deputy Medical Examiner
Address: Westminster Md M. D. or other
Date signed: 3/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-E)

CERTIFICATE OF DEATH

02495

Reg. Dist. No. 42.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster RD#2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 91 yrs

Hospital, institution, or street address where death occurred: Westminster RD #2.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Westminster RD#2.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Barbara J. Bechtel

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	widow

6.(b) Name of husband or wife: William F. Bechtel

6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): 7/4/1855

8. AGE: Years: 91 | Months: 1 | Days: 6 | If less than one day: — hrs. — min.

9. Birthplace: Carroll Co Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Levi Peterman

13. Birthplace: Carroll Co Md.

MOTHER — 14. Maiden name: Martha Hymon

15. Birthplace: York Co Pa.

16. Informant: C. C. Bechtel

Address: 43 Frederick St Hanover Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 17 1946 (month) (day) (year)

Cemetery or crematory: St. Bartholomews

Location: Hanover RD #2, York Co Penn

16. Funeral director: H. Eckard Sons

Address: 254 E. Main Street Westminster

19. 3-15- 1946 (Date rec'd by registrar) Calvin E. Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/14 19 46, at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 19— to 3/14 1946

and that I last saw h— alive on 3/12 1946

Immediate cause of death	DURATION
Senility	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Glenn Coleman M.D.

M. D. or other

Address: 120 Frederick St Date signed 3/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02496

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 8 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 month, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 632 N. Fulton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mary Isabella Bleakley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Samuel A. Bleakley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 12, 1877

8. AGE: Years	Months	Days	If less than one day
68	10	10	hrs. min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John Dutton

13. Birthplace: Maryland (Balto.)

MOTHER — 14. Maiden name: Mary I. McLaughlin

15. Birthplace: Maryland (Balto.)

16. Informant: Records of Springfield State Hospital, Sykesville, Maryland
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/25/46 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WILLIAM J. TICKNER & SONS

Address: Balto., Md.

19. 3-25 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/22 1946, at 5:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/14/46 1946 to 3/22/ 1946 and that I last saw h... alive on 3/22/ 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	½ hr.
Hemiplegia	
Due to: Arteriosclerosis	—
Due to:	
Other conditions: Senile Dementia	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other

Address: Springfield State Hosp. Sykesville Md. Date signed: 3-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

3021

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02497

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yr., 4 mo., 1 day
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 yr., 4 mo., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Vincent Bonica

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10, 1911

8. AGE: Years	Months	Days	If less than one day
34	10	3	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation: blacksmith
11. Industry or business

FATHER
12. Name: Charles Bonica
13. Birthplace: Italy

MOTHER
14. Maiden name: Grace Sciacca
15. Birthplace: Italy

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/18/46 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Delaware Rd. & Waverly Ave.
18. Funeral director: Frank Della Rocca
Address: 52 N. Monday St.

19. Mar. 14 1946 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1946, at 5:27 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943 to March 13, 1946 and that I last saw him alive on March 13, 1946

Immediate cause of death	DURATION
Bronchopneumonia	24 hrs.
Due to:	
Due to:	
Other conditions: Dementia precox, paranoid type (Include pregnancy within 3 months of death)	13 yrs.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other
Springfield State Hospital
Address: Sykesville, Maryland Date signed 3-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02498

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: 1 year 49 days
Hospital, institution, or street address where death occurred: Springfield State Hosp
How long in hospital or institution: 1 yr 49 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1904 Wilkins Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John J. Cantwell Sr.

3.(b) Social Security Number:

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Elizabeth
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.): 9-8-1874

8. AGE: Years 71 Months 6 Days 7 If less than one day .... hrs. .... min.

9. Birthplace: Chicago, Illinois (Town, county, and state)
10. Usual occupation: Dining car steward
11. Industry or business:
FATHER 12. Name: John Cantwell
13. Birthplace: Ireland
MOTHER 14. Maiden name: Unknown
15. Birthplace: England
16. Informant: Mrs. Irving J. Dixon
Address: 1904 Wilkins Ave Baltimore Md
17. burial (Burial, cremation, or removal, Which?) Date thereof: 3/19/46 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem
Location: 4300 Old Frederick Rd
18. Funeral director: John J. Cowan & Son
Address: 901-03 Hollins St.
19. 3-15 1946 (Date rec'd by registrar) A W Hedrick asst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-15 1946, at 9 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 25 1945, to March 15 1946
and that I last saw h.... alive on .... 19....

	DURATION
Immediate cause of death: Myocarditis, chronic	1 year
Due to:	
Due to:	
Other conditions: TB of lungs, arteriosclerosis with psych. (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jno. C. Kamm M. D. or other
Address: Springfield State Hosp. Date signed: 3-15-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02499 Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Springfield State Hospital, Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos., 5 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 8 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ?
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Williams Chambliss

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Eliza D. Richardson
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 3, 1859

8. AGE: Years	Months	Days	If less than one day
86	9	4	..... hrs. ..... min.

9. Birthplace: Warrenton, N. C.
(Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business
FATHER 12. Name: Jackson Chambliss
13. Birthplace: Mississippi
MOTHER 14. Maiden name: Catherine V. Williams
15. Birthplace: North Carolina
16. Informant: Peter Chambliss
Address: Round Bay, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-11-46 (month) (day) (year)
Cemetery or crematory: Woodlawn Cem.
Location: Balto. Md.
18. Funeral director: John O. Mitchell & Sons
Address: 1960 Eutaw Place
19. Mar. 8 1946 (Date rec'd by registrar) C. Haney Edes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1946, at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11, 1946, to March 7, 1946
and that I last saw h~~im~~ alive on March 7, 1946

Immediate cause of death	DURATION
Coronary occlusion	30 mins.
Due to: Generalized arteriosclerosis	At least 4 yrs.
Due to: Chronic myocarditis	" " "
Other conditions: Senile psychosis	11 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Springfield State Hospital Date signed: March 7, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

03110

Reg. Diat. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Edgar B. Crumbacker

3.(b) Social Security Number: 215-18-1243

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lottie L Crumbacker

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 15 - 1869

8. AGE:	Years	Months	Days	If less than one day
	76	11	19	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Day

FATHER
12. Name: Jesse Crumbacker
13. Birthplace: Maryland

MOTHER
14. Maiden name: Celia Otto
15. Birthplace: Maryland

16. Informant: Mrs Lottie L Crumbacker

Address: Union Bridge Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 28-1946 (month) (day) (year)

Cemetery or crematory: Rocky Ridge Brethern Cem.

Location: Rocky Ridge Maryland

18. Funeral director: D. D. Hartter & Son

Address: Union Bridge & New Windsor Md

19. March 28, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 26, 1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 24, 1946, to Mar. 26, 1946 and that I last saw h... alive on Mar. 26, 1946

	DURATION
Immediate cause of death: Gangrene of intestine	3 days
Due to: Strangulated inguinal hernia (later operated upon)	12 hrs. (5 days ago)
Due to:	
Other conditions: Terminal bronchopneumonia, uremia (Include pregnancy within 3 months of death)	2-3 d

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E L Seigman M. D. or other

Address: Union Bridge Date signed: 3/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02560

Reg. Dist. No. 78

1. PLACE OF DEATH:
County: Carroll
City or town: near Mt. Olive
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: near Mt Olive
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. Woodbine
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Francis T. Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1869

8. AGE: Years	Months	Days	If less than one day
76	9	13	hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Francis T. Davis
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Ann Hammond
15. Birthplace: Maryland

16. Informant: Mr. Atlee Davis
Address: Woodbine, Md.

17. (Burial, ~~cremation, or removal. Which?~~) Burial Date thereof (month) (day) (year) 3-13-46
Cemetery or crematory: Davis Family Lot
Location: Mt. Olive, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md

19. (Date rec'd by registrar) 3-12-46 E. M. Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1946, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner M. D. or other
Address: Westminster Md Date signed: Mar 11-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-6

CERTIFICATE OF DEATH

★ 12506 Reg. Dist. No. 96

1. PLACE OF DEATH:
County Carroll Co.
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? most of her life
Hospital, institution, or street address where death occurred:
Charles St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Summers Dorm

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	Col.	married

6.(b) Name of husband or wife Howell S. Dorm
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) ? 1888

8. AGE: Years 58 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Old Fell, Fred Co. Md.
(Town, county, and state)

10. Usual occupation house servant

11. Industry or business

FATHER
12. Name Thomas Summers
13. Birthplace Virginia

MOTHER
14. Maiden name Annie Biggs
15. Birthplace Fred Co. Md.

16. Informant Howell S. Dorm
Address Charles St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3 46 (month) (day) (year)
Cemetery or crematory Ellsworth Cemetery
Location near Westminster, Md

18. Funeral director J. E. Myers & Son
Address Westminster Md.

19. 4/ 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1945 to March 30 1946
and that I last saw h[illegible] alive on March 30 1946

Immediate cause of death	DURATION
Carcinoma Uteri	
" Lungs	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jemmette, M.D. M. D. or other
Address Westminster Md. Date signed 4-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Original

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02502

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 21 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1003 Pennsylvania Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME GEORGE RICHARD DUMAS

3.(b) Social Security Number

4. Sex: male
5. Color or race: col.
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Dorothy Dumas
6.(c) If alive, give age 28 years
7. Birth date of deceased (mo., day, yr.): November 13, 1915

8. AGE:	Years	Months	Days	If less than one day
	30	4	12	....hrs. ....min.

9. Birthplace Atlanta, Ga. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Thomas Dumas
13. Birthplace Eden, Ga.
MOTHER 14. Maiden name Pearline Adams
15. Birthplace Monroe, Ga.
16. Informant I.B. Lyon, M.D.
Address Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-1-46 (month) (day) (year)
Cemetery or crematory Woodlawn Cemetery
Location Washington, D.C.
18. Funeral director ~~Mrs. Katie E. Williams~~ Mrs. S. T. Hensley
Address ~~822 N. Schroeder St.~~ 578 W. Biddle
19. 3-25-46 (Date rec'd by registrar) Albert R. Swackhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1946 at 2:50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4, 1945 to March 25, 1946 and that I last saw him alive on March 25, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE I. B. Lyon M. D. ~~or other~~
Address Henryton, Md. Date signed 3-25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

02503

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-12M

1. PLACE OF DEATH:

County: Carroll

City or town: Springfield State Hospital, Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 3 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 2 yrs., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Rural, Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route # 4

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME John J. Eshelman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 24, 1920

8. AGE: Years	Months	Days	If less than one day
26	1	11	hrs. min.

9. Birthplace: ? (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Jonas Eshelman

13. Birthplace: Md.

MOTHER 14. Maiden name: Nora Gebhardt

15. Birthplace: Pa.

16. Informant: Father

Address: P.O. Box 227, Williamsport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 11, 1946 (month) (day) (year)

Cemetery or crematory: Manor

Location: Clearspring Md.

18. Funeral director: Edith V. Feat

Address: Williamsport Md

19. Mar. 8 1946 (Date rec'd by registrar) C. Henry Rice Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1946, at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Feb. 1946 to 7 March 1946 and that I last saw him alive on 7 March 1946

Immediate cause of death	DURATION
Tuberculous pneumonia	Few days
Due to: Tuberculosis	unknown — less than 3 yrs.
Due to: Diabetes mellitus	8 yrs.
Due to:	
Other conditions: Psychosis with somatic disease, diabetes mellitus	6 1/2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: March 7, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02504

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? R. D. #5
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. D. #5
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Flickinger

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Guy Flickinger
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): July 3 - 1888
8. AGE: Years: 57 Months: 8 Days: 28 If less than one day: ..... hrs. ..... min.
9. Birthplace: Carroll County Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Washington Wetzel
13. Birthplace: Maryland
MOTHER 14. Maiden name: Martha Harris
15. Birthplace: Maryland
16. Informant: Myrtle D. Stultz
Address: Westminster Md. R. D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 3 - 1946 (month) (day) (year)
Cemetery or crematory: Salem Methodist Cem.
Location: Winfield Md R. D.
18. Funeral director: W. H. Hartsler & Sons
Address: Union Bridge & New Windsor Md
19. Apr 2 - 1946 (Date rec'd by registrar) Ray Zepp Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1946 at 9:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930 19..., to March 31 1946
and that I last saw her alive on March 31 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 day.
Due to:	
Due to:	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. C. Jarrett M.D. M. D. or other
Address: Westminster Md Date signed: 4-2-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

02505

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md. —
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months 28 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 7 months 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Cambridge - Md -
(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 Maryland Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Earl Fogelsonger —

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 31, 1913 —

8. AGE:	Years	Months	Days	If less than one day
	32	2	11	...hrs. ...min.

9. Birthplace Shippensburg Penna — (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Lee Fogelsonger

13. Birthplace Shippensburg, Penna —

MOTHER 14. Maiden name Emma Baker

15. Birthplace Pennsylvania —

16. Informant Mrs. Mary Cross

Address 2439 Liberty St. Allentown, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 15, 1946 (month) (day) (year)

Cemetery or crematory Middle Spring Cem.

Location Middle Spring, Pa.

18. Funeral director C. Harry Weed

Address Sykesville, Md.

19. Mar. 12 1946 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 2:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12th 1945 to March 12 1946 and that I last saw h.. alive on March 11 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 months
Due to	
Due to	
Other conditions Mental Deficiency	Life

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

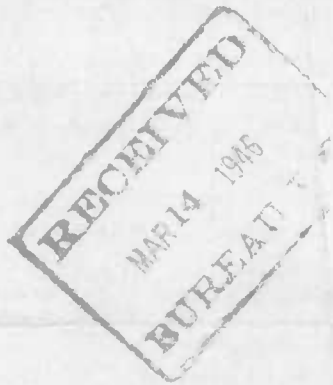
23. SIGNATURE M. Virginia Berger M.D. (M. D. or other)

Address Sykesville, Md. Date signed 3-12-'46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-E

CERTIFICATE OF DEATH

02506

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 5 mos., 24 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1 Covington Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH ROOSEVELT FRANKLIN

3.(b) Social Security Number: 220-10-8497

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 14, 1912

8. AGE: Years	Months	Days	If less than one day
33	7	18	hrs. min.

9. Birthplace: Norfolk, Va. (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business:
FATHER 12. Name: John Henry Franklin
13. Birthplace: Virginia
MOTHER 14. Maiden name: Magdalene Griffin
15. Birthplace: Virginia
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-5-46 (month) (day) (year)
Cemetery or crematory: Coolsville Cem
Location: Coolsville Md.
18. Funeral director: B.C. Hyndeathorn
Address: Ellicott City Md.
19. March 2, 1946 (Date rec'd by registrar) Albert E. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2, 1946, at 12:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 8, 1942, to March 2, 1946 and that I last saw him alive on March 2, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	August 1 1942
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 3-2-46

VS A15 9.45-12M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02507

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mo's, 6 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Lakeland Park, Box 148
(If outside city or town limits, write RURAL and give nearest town)
Street No. xxx Rockville, Post Office.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ROLAND ALFONSO GRAY

3.(b) Social Security Number 579-22-2485

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 25, 1922

8. AGE: Years	Months	Days	If less than one day
23	8	12	..... hrs. ..... min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation Laundry Worker
11. Industry or business

FATHER
12. Name Russell Gray
13. Birthplace Martinsburg, Maryland.

MOTHER
14. Maiden name Ermenie Palmer
15. Birthplace Germantown, Md.

16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 7 1946 (month) (day) (year)
Cemetery or crematory Rockville md
Location
18. Funeral director Robert L. Lowndes
Address Rockville md

19. 3/7 (Date rec'd by registrar) 19 46 Albert C. Trundle Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1946 at 2.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1946 to March 7, 1946
and that I last saw h~~im~~ alive on March 7, 1946

Immediate cause of death Pulmonary Tuberculosis — DURATION Sept, 11 1945
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 3/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 02508 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Carroll

City or town Eldersburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Eldersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. Lykesville P.O.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nellie L. Gibson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife W. Pagwell Gibson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 10, 1870

8. AGE: Years 75 | Months 8 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name George Yingling
13. Birthplace Md.

MOTHER
14. Maiden name Unk -
15. Birthplace Unk -

16. Informant Mr. W Pagwell Gibson

Address Lykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-29-46 (month) (day) (year)

Cemetery or crematory Calvary Cemetery

Location Sanders, Carroll Co. Md.

18. Funeral director C. Harry Weer

Address Lykesville, Md.

19. Mar 26 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1946 at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 19 to 3/25 1946

and that I last saw her alive on 3/25/46 19

Immediate cause of death	DURATION
rupture of middle meningeal artery - right -	2 days
Due to cerebral arteriosclerosis	10 yrs
Due to hypertensive cardiovascular disease with arteriosclerosis	?
Other conditions senility.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Lawrence M.D.
M. D. or other

Address Lykesville Date signed 3/25/46

Original must be filed by Department of Health

MARYLAND STATE DEPARTMENT OF HEALTH

02510

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 2 mo's, 22 days
Hospital, institution, or street address where death occurred:
Md. Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: DAVID ALBERT GROOMES

3.(b) Social Security Number: 184-10-7960

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept., 8, 1909

8. AGE: Years	Months	Days	If less than one day
36	6	13	..... hrs. ..... min.

9. Birthplace: Sykesville, Md. (Town, county, and state)
10. Usual occupation: Defense Worker
11. Industry or business

FATHER
12. Name: David Groomes
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden name: Anna Dorsey
15. Birthplace: Woodstock, Md.

16. Informant: T. B. Lyon, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-25-46 (month) (day) (year)
Cemetery or crematory: White Rock.
Location: Near Berret, Md.
18. Funeral director: C. M. Waltz.
Address: Winfield Md.

19. 3/21 19 46 (Date rec'd by registrar) Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 19 46 at 3.20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29, 19 45 to March 21, 19 46 and that I last saw him alive on March 21, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	15 Mo's
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: T. B. Lyon M. D. or other
Address: Henryton, Md. Date signed: 3/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

02511

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 94

1. PLACE OF DEATH:

County Carroll

City or town Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Gaither Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henson Richard Groomes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Widowed

6.(b) Name of husband or wife Virginia Groomes

6.(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) March 28, 1866

8. AGE: Years	Months	Days	If less than one day
79	11	24	....hrs. ....min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Nicholas Groomes

13. Birthplace Md.

MOTHER 14. Maiden name Ellen Dorsey

15. Birthplace Md.

16. Informant James Groomes

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-26-46 (month) (day) (year)

Cemetery or crematory Johnsville Cem.

Location Johnsville, Carroll Co., Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. Mar. 23 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1946, at 9:00 P. M.

21. I CERTIFY that death occurred on the date above etated; that I attended deceaced from 1943 19.. to death 19.. and that I last saw h im alive on March 22 1946

Immediate cause of death	DURATION
Hypertensive cardiovascular disease with arteriosclerosis	
Due to senile changes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lawrence M.D. M.D. or other

Address Sykesville Date signed 3/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-d)

02512

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John David Haines

3.(b) Social Security Number 217-12-2455

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband ~~or wife~~: Mrs. Rose Haines

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 15-1883

8. AGE: Years	Months	Days	If less than one day
62	3	12	hrs. min.

9. Birthplace: Carroll County, Md.

(Town, county, and state)

10. Usual occupation: Mason and Carpenter

11. Industry or business

FATHER — 12. Name: Charles Haines

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Frances Stern

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Rose Haines

Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 30-1946 (month) (day) (year)

Cemetery or crematory: Presbyterian Cemetery

Location: New Windsor, Md.

18. Funeral director: H. H. Hartsock & Sons

Address: Union Bridge & New Windsor, Md.

19. Mar 30 1946 (Date rec'd by registrar) Chas. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1946 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Mar 27 1946 and that I last saw him alive on March 27 1946

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular disease	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Hamrick M. D. or other

Address: Westminster Md. Date signed: Mar 28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02513 74
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 809 S. Greene Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MAGGIE HELLER

3.(b) Social Security Number: 219-05-1715

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 30, 1908

8. AGE: Years: 37 Months: 4 Days: 25 If less than one day: hrs. min.

9. Birthplace: Columbia, S.C.
(Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business:

FATHER
12. Name: Adam Heller
13. Birthplace: Columbia, S.C.

MOTHER
14. Maiden name: Maggie Neles
15. Birthplace: Columbia, S.C.

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: 3/29/46 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A A Co Md
18. Funeral director: Isaiah D. Brown Sr.
Address: 408 W Montgomery St

19. (Date rec'd by registrar): March 25, 19 46
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25, 1946, at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1946 to March 25, 1946 and that I last saw her alive on March 25, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1 year
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D. or other
Address: Henryton, Md. Date signed: 3-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02514

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 637 Dover St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPHINE HENRY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12, 1928

8. AGE: Years	Months	Days	If less than one day
17	8	26	hrs. min.

9. Birthplace: Abbeville, S. C.
(Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business: at school
FATHER 12. Name: James Henry
FATHER 13. Birthplace: South Carolina
MOTHER 14. Maiden name: Nannie O. Pratt
MOTHER 15. Birthplace: South Carolina
16. Informant: I. B. Lyon, M. D.
Address: Henryton, Md.
17. Shipped (Burial, cremation, or removal. Which?) Date thereof 3/11/46 (month) (day) (year)
Cemetery or crematory:
Location: Abbeville, S.C.
18. Funeral director: Mrs. Katie R. Wilkes
Address: 322 N. Schroeder St.
19. 3/8 (Date rec'd by registrar) 19 46 Albert R. Lyon Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8, 19 46 at 7.55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 19 46, to March 8, 19 46 and that I last saw her alive on March 8, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 Month
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D. or other
Address: Henryton, Md Date signed: 3/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02515 76

1. PLACE OF DEATH:

County Carroll

City or town Mr Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:
Carroll County Home

How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Humbert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 11, 1860

8. AGE: Years 85 | Months 8 | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace U

MOTHER 14. Maiden name

15. Birthplace U

16. Informant Carroll County Home

Address Westminster, Md.

17. Burial Date thereof May 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baust Cemetery

Location Mr - Taneytown, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown Md

19. 3/12 19 46 H. L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 - 11 - 46 19 ..... at 11.15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19 44, to 3 - 12 19 46 and that I last saw h... alive on 3 - 11 - 19 46.

	DURATION
Immediate cause of death Pulmonary Edema	5 days
Due to Cardiac decompensation	10 days
Due to Arteriosclerosis	8 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. C. Howe M. D. or other

Address Westminster Date signed 3-12-46

02516

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66 - 2m - 14

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Sullivan Road

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Irvin Leander Hunter

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Alice Grace Hull

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan. 8 - 1880

8. AGE:	Years	Months	Days	If less than one day
	66	2	14	..... hrs. ..... min.

9. Birthplace Winnemac Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Joseph J. Hunter

13. Birthplace Westminster Md.

MOTHER

14. Maiden name Mary E. Copperssmith

15. Birthplace Westminster, Md.

16. Informant Paul Irvin Hunter

Address Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 25. 1946 (month) (day) (year)

Cemetery or crematory Krider's cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 3/23 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1946 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1946 to March 24 1946 and that I last saw him alive on March 2 1946

Immediate cause of death	Emphysema	DURATION
Due to	Heart Complications	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J Stewart M. D. or other

Address Westminster Md Date signed March 23 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-1)

02517

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred:
M. P. Church Home for Aged
How long in hospital or institution? 11 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: East Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Florence Hyson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 28, 1856

8. AGE: Years: 89 | Months: 6 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Chestertown, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: William S. Hyson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Keturah Sater
15. Birthplace: Maryland

16. Informant: Mrs. Ober S. Herr
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/18/46 (month) (day) (year)
Cemetery or crematory: Mount Zion Cemetery
Location: Freeland, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 3/16 19 46 (Date rec'd by registrar) E. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 19 46, at 10:50 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1940, to Mar. 16 19 46
and that I last saw h[illegible] alive on Mar. 10 19 46

	DURATION
Immediate cause of death: Cardiac Decompensation	1 mo
Due to: Chronic Myocarditis	6 yr.
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. K. Woodward M. D. or other
Address: Westminster Date signed: 3/16/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02518

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Lyksville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Lyksville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Donald Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10, 1927

8. AGE: Years 18 | Months 3 | Days 6 | If less than one day ... hrs. ... min.

9. Birthplace Lyksville, Md. (Town, county, and state)

10. Usual occupation Boy.

11. Industry or business

FATHER 12. Name James Johnson

13. Birthplace Md.

MOTHER 14. Maiden name Lucille Anderson

15. Birthplace Md.

16. Informant James Johnson

Address Lyksville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-20-46 (month) (day) (year)

Cemetery or crematory St. Lukes Cem.

Location Lyksville, Md.

16. Funeral director C. Harvey Zile

Address Lyksville, Md.

19. Mar. 19 1946 (Date rec'd by registrar) C. Harvey Zile Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1946, at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1945 to death 1946

and that I last saw him alive on 3/15/46 1946

Immediate cause of death	DURATION
acute pulmonary tuberculosis	6 mos (?)
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Lawson, M.D. M. D. or other

Address Lyksville Date signed 3/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02519

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yr., 1 mo., 10 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 33 yr., 1 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Keefer

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Susan Hahn Keefer
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): 1872 - March - 1st

8. AGE: Years	Months	Days	If less than one day
74	0	19	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: agriculture

FATHER
12. Name: Joseph Keefer
13. Birthplace: Adams Co. Pennsylvania

MOTHER
14. Maiden name: Amanda Bair
15. Birthplace: Adams Co. Penna.

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 23 1946 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Silver Run, Md.

18. Funeral director: T. M. Little & Son
Address: Littlestown, PA, R.F.D. 4

19. Mar. 21 1946 (Date rec'd by registrar) C. Henry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 1946 at 4:40p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to March 20 1946 and that I last saw him alive on March 20 1946

Immediate cause of death	DURATION
Coronary occlusion	instant
Due to	
Due to	
Other conditions: Schizophrenia, catatonic type	40 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 3-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02520

CERTIFICATE OF DEATH

Reg. Diat. No. 16

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 84 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anna Elizabeth Kemper

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Henry E. Kemper
6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) May 26 1861

8. AGE:	Years	Months	Days	If less than one day
	84	11	5	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Alexandria Little
13. Birthplace Md. Carroll Co.
MOTHER 14. Maiden name Elizabeth Coppersmith
15. Birthplace Md.
16. Informant Mrs Anna Fritz
Address Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 3 - 1946 (month) (day) (year)
Cemetery or crematory Kriders Cemetery
Location Westminster, Md.
18. Funeral director H.B. Bankard & Son
Address Westminster Md.
19. 3/2 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 1946, at 7 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1946, to March 1st 1946
and that I last saw him alive on Feb. 26th 1946

Immediate cause of death	DURATION
Organic Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Ford Stewart M. D. or other
Address Westminster Md. Date signed March 1st 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03111

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 2 months, 4 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 years, 2 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Standish Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Michael Kirby

3.(b) Social Security Number:

4. Sex: Male

5. Color or Race: White

6.(a) Single, Married, Widowed, or Divorced: Married

6.(b) Name of husband or wife: Sarah J. Kirby

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 28, 1878

8. AGE: Years: 67 Months: 7 Days: 10days If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Lineman

11. Industry or business:

FATHER 12. Name: John Kirby

13. Birthplace: Virginia

MOTHER 14. Maiden name: Mary Devlin

15. Birthplace: Scotland

16. Informant: Records of Springfield State Hosp.

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-11-46 (month) (day) (year)

Cemetery or crematory: Frostburg

Location: Frostburg, Allegany Co., Md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. Mar 9 1946 (Date rec'd by registrar) C. Harry Wen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/8/ 1946, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4, 1941, to March 8, 1946 and that I last saw him alive on March 8, 1946

Immediate cause of death: Bronchopneumonia and chronic myocarditis with myocardial degeneration — DURATION: 4 days

Due to: Accidental fall; slipped and fell, on the ice C.W.R. — DURATION: 2 yrs.

Due to: ..... — DURATION: .....

Other conditions: Psychosis with somatic disease. Fractured femur 12/29/45 — DURATION: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: December 25, 1945

Where did injury occur? Springfield State Hospital (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: M Virginia Beyer M.D. (M. D. or other)

Address: Sykesville, Maryland Date signed: 3/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02521 74
Reg. Dist. No.

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Maryland -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years - 2 month 23 days -
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 yrs - 2 months - 23 days -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 N. Curley Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Suenemann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Unknown
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) August 15, 1860 -

8. AGE: Years	Months	Days	If less than one day
85	7	2	hrs. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation None -
11. Industry or business
FATHER 12. Name John Eilts
13. Birthplace Germany
MOTHER 14. Maiden name Frederika Sost
15. Birthplace Germany
16. Informant Hospital Records
Address Sykesville, Md -
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-19-46 (month) (day) (year)
Cemetery or crematory Priority Cem.
Location Balto. Md.
18. Funeral director John W. Lueck
Address 2008 Orleans St.
19. Mar. 17 1946 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17th 1946, at 6:25 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22 1937, to March 17 1946
and that I last saw h...r alive on March 16 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1939 -
Due to	
Due to	
Other conditions Psychosis with Cerebral Arteriasclerosis (Include pregnancy within 3 months of death)	1937

Major findings of operations
Date of op.
Autopsy results For advanced Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other
Address Sykesville, Md Date signed 3-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

02522

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-12M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.-5 mo.-9 da.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 10 yrs.-5 mo.-9 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No.: 148 East Washington Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ESTELLE MAGAHA

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 25, 1886

8. AGE:

Years	Months	Days	If less than one day
59	4	8	..... hrs. ..... min.

9. Birthplace: Washington County, Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER 12. Name: Conrad Kreitz

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Mary E. Moran

MOTHER 15. Birthplace: Washington County, Maryland

16. Informant: Hospital Records

Address: Sykesville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4, 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown Md

18. Funeral director: Leoth & Minnick Son

Address: Hagerstown Md.

19. Mar. 2 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1946, at 5.15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 1946, to March 2 1946

and that I last saw her alive on March 2 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	18 da.
Due to: Cerebral Arteriosclerosis	10 yrs.
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Mary M. Rice M.D. (M. D. or other)

Address: Sykesville Md. Date signed 3-2-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

02523

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 m - 5 - 21
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Sylvester Orlando Naill

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Amy Elma

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 12 — 1881

8. AGE: Years	Months	Days	If less than one day
64	3	21	...hrs. ...min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
12. Name of father Josias Naill
13. Birthplace of father Md.
14. Maiden name of mother Mary Knott
15. Birthplace of mother Md.
16. Informant Amy Elma
Address Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 6 - 1946 (month) (day) (year)
Cemetery or crematory Woodlawn Cemetery
Location Baltimore Md.
18. Funeral director H. Bankard & Son
Address Westminster Md.
19. 3/4 19 46 H. Woodward (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946 at 9:35 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10, 1946 to Mar 3, 1946 and that I last saw him alive on Feb 21 1946

	DURATION
Immediate cause of death: Coronary occlusion	20 minutes
Due to: Coronary disease (Heart symptoms)	2 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE E. Reese Wilkens M.D. M. D. or other
Address Westminster Date signed 3/4/46

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

02524

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:
County Carroll
City or town Fuzzilburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 67 - 9 - 17
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Harry Jacob Null

3. (b) Social Security Number 218-22-9817

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Mary Myerly
6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) July 1 - 1878

8. AGE:	Years	Months	Days	If less than one day
	67	8	17	...hrs. ...min.

9. Birthplace Fuzzilburg Carroll Co Md.
(Town, county, and state)
10. Usual occupation Farmer + Laborer
11. Industry or business Bethlehem Fairfield Shipyards
FATHER 12. Name Jacob
13. Birthplace Germany
MOTHER 14. Maiden name Emily Myers
15. Birthplace Carroll Co. Md.
16. Informant Russell Null
Address Fuzzilburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 21 1946 (month) (day) (year)
Cemetery or crematory Trinity Cemetery
Location Westminster Md.
18. Funeral director A Bankard & Son
Address Westminster, Md.
19. Mch 20 1946 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1946 at 1:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1946 to March 18 1946 and that I last saw h... alive on March 18 1946
Immediate cause of death Cerebral Hemorrhage — DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J Stegmaier M. D. or other
Address Westminster Md. Date signed March 20 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-d)

CERTIFICATE OF DEATH

02525

Reg. Diat. No. 70 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster R #4
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Lowe Nusbaum

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Warren Nusbaum

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1878

8. AGE: Years	Months	Days	If less than one day
68	1	11	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER 12. Name Alfred Lowe

13. Birthplace Md.

MOTHER 14. Maiden name Annie Brothers

15. Birthplace Md.

16. Informant Mrs. Benj. Gist

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/9/46 (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Uniontown, Md.

18. Funeral director C.O. Fuss & Son

Address Taneytown, Md.

19. March 9. 1946 (Date rec'd by registrar) Ethel M Melvin Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1946, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940, to mar. 5 1946 and that I last saw h. on live on mar 5 1946

Immediate cause of death	DURATION
Hemiplegia	4 mos.
Due to Cerebral arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E Rees Wilkens M.D.
M. D. or other

Address Westminster Date signed 3/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02526

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yr., 6 mo., 10 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 30 yr., 6 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John J. O'Brien

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

8.(b) Name of husband or wife: unknown
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
86 (?)			hrs. min.

8. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business:

FATHER
12. Name: John O'Brien
13. Birthplace: Ireland

MOTHER
14. Maiden name: Ellen Murphy
15. Birthplace: Ireland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 1946 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. April 1, 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30, 1946, at 7:15a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1, 1943, to March 30, 1946
and that I last saw h im alive on March 29, 1946

Immediate cause of death	DURATION
General paralysis of the insane and tabes dorsalis	32 yrs.
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Antopsy results: See cause of death
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 4-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

02527

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, institution, or street address where death occurred:

36 W. George St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 36 W. George St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elmira Fisher Phillips

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widowed

6.(b) Name of husband or wife J. Alfred Phillips

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 26, 1862

8. AGE:

Years	Months	Days	If less than one day
83	11	18	..... hrs. ..... min.

9. Birthplace Baltimore City Md.

(Town, county, and state)

10. Usual occupation (invalid)

11. Industry or business

FATHER 12. Name Albert N. Fisher

13. Birthplace Shrewsbury Pa.

MOTHER 14. Maiden name Jane Cherry

15. Birthplace Frederick Md.

16. Informant Mrs. Herbert M. Phillips

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 / 17 / 46 (month) (day) (year)

Cemetery or crematory Deer Park Cemetery

Location Uniontown Road, near Westminster Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. 3/14 - 46 (Date rec'd by registrar) 19..... E. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March ~~April~~ 14 19 46 at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 36 to ~~April~~ 14 19 46 and that I last saw h~~e~~r alive on ~~April~~ 14 19 46

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr)	
Due to	
Due to Hypertension	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jamuth M.D. M. D. or other

Address Westminster Md Date signed 3-15-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

02528

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Greenville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Greenville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sykesville P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Oliver C. Phillips

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Mary C.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1862

8. AGE:

Years	Months	Days	If less than one day
83	2	23	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Joshua Phillips

13. Birthplace: Md.

MOTHER

14. Maiden name: Sarah Humphrey

15. Birthplace: Md.

16. Informant: Miss Catherine Phillips

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-13-46 (month) (day) (year)

Cemetery or crematory: New Oakland Cem.

Location: Mt. Oakland Mills, Carroll Co. Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Mar. 12 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1946, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 11 1946, to Mar. 11, 1946 and that I last saw him alive on Mar. 11, 1946

Immediate cause of death	DURATION
Coronary Thrombosis	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Date signed 3/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02529

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16 9-45-1

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 127 Prague Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES PITCHFORD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1889

8. AGE:

Years	Months	Days	If less than one day
57	2	26	hrs. min.

9. Birthplace: Jetersville, Va.
(Town, county, and state)

10. Usual occupation: Plasterer

11. Industry or business:

FATHER
12. Name: James Pitchford, Sr.
13. Birthplace: Virginia

MOTHER
14. Maiden name: Rosa Smith
15. Birthplace: Virginia

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Removal Date thereof 3/30/46 (month) (day) (year)
Cemetery or crematory: Baltimore City Morgue
Location: Baltimore, Md.

18. Funeral director: Francis H. Sheeley
Address: 518 W. Biddle St

19. March 27, 19 46 (Date rec'd by registrar) Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27, 1946 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1946 to March 27, 1946 and that I last saw him alive on March 27, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D. or other
Address: Henryton, Md. Date signed 3-27-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

02530

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 23 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 6 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State: Maryland County: Montgomery
City or town: Damascus
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Reuben Newton Poole

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Gertrude Purdum
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 21, 1868

8. AGE: Years	Months	Days	If less than one day
77	4	1	hrs. min.

9. Birthplace: Montgomery County, Maryland (Town, county, and state)
10. Usual occupation: farmer
11. Industry or business: agriculture

FATHER
12. Name: Warner Poole
13. Birthplace: Montgomery County, Maryland

MOTHER
14. Maiden name: Evelyne Becraft
15. Birthplace: Montgomery County, Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-25-46 (month) (day) (year)
Cemetery or crematory: Damascus
Location: Damascus Md.
18. Funeral director: J. B. Beall, Inc.
Address: Damascus, Md.

19. Mar. 22 19 46 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 46 at 1:55p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 19 45 to March 22 19 46 and that I last saw him alive on March 22 19 46

Immediate cause of death	DURATION
Senility and arteriosclerosis	20 yrs.
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May MD
Springfield State Hospital M.D. or other
Address: Sykesville, Maryland Date signed: 3-22-46

M

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 112531 3376

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days): 1 month
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Cwings Mills Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: John Bell Reese

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Katherine Reese

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 16, 1860

8. AGE: Years	Months	Days	If less than one day
85	11	20	hrs. min.

9. Birthplace: Balto.Co. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: John R.Reese
13. Birthplace: Carroll Co.

MOTHER
14. Maiden name: Elizabeth Roop
15. Birthplace: Carroll Co.

16. Informant: Mrs.Sidney Reese
Address: Cwings Mills,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 11,1946 (month) (day) (year)
Cemetery or crematory: St.Thomas
Location: Balto.Co.

18. Funeral director: J.F.Eline & Sons
Address: Reisterstown,Md.

19. 3-11 1946 (Date rec'd by registrar) O.B.Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1946, at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1939 to Mar 8 1946 and that I last saw him alive on March 7 1946

Immediate cause of death: Cancer of bladder — DURATION: 8 mos +

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: R.E. Carbaugh M.D.
M. D. or other
Address: Westminster Md. Date signed: 3/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

not to

02532

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Frederick
City or town Emmitsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Victor E Rowe

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Mattie Rowe
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 2, 1858

8. AGE: Years	Months	Days	If less than one day
87	8	18	..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Farmer & Laborer
11. Industry or business

FATHER
12. Name Chas J Rowe
13. Birthplace Md

MOTHER
14. Maiden name Eliza Maxell
15. Birthplace Md

18. Informant Mrs S Bolt
Address Taneytown Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof 3/22/1946 (month) (day) (year)
Cemetery or crematory Mountain View
Location Emmitsburg Md
18. Funeral director C D Sturs & Son
Address Taneytown Md

19. (Date rec'd by registrar) March 22 1946 Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20th 1946 at 7.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 16 1946 to Mar. 20 1946 and that I last saw h alive on Mar. 16th 1946

Immediate cause of death	DURATION
Uraemia Interstitial Nephritis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Francis J Elliot M.D.
M. D. or other
Address Taneytown Md Date signed 3/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02533

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 7 mo 26 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 year 7 mo 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 716 West Bay Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

EVELYN EDNA RUARK

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Melvin W. Ruark

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
apparent 54			....hrs. ....min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: clerk

11. Industry or business: Baltimore Clothing House

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-16-46 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Klee

Address: Sykesville, Md.

19. Mar. 16 19 46 C. Harry Klee
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1946, at 9.20 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1st 1944 to Mar. 14 1946 and that I last saw her alive on March 14 1946

Immediate cause of death	DURATION
Syphilitic Meningo-encephalitis	13 yrs.
Due to:	
Due to:	
Other conditions: Psychosis with Syphilitic Meningo-encephalitis	13 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Maud M. Rees M.D.
M. D. or other

Address: Sykesville Md Date signed: 3-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1500

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02534

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 695 W. Mulberry Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROBERT RUSSELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2, 1904

8. AGE: Years	Months	Days	If less than one day
41	10	25	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: George Russell
13. Birthplace: Unknown

MOTHER
14. Maiden name: Janie Reed
15. Birthplace: Unknown

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/1946 (month) (day) (year)
Cemetery or crematory: Amt Carroll
Location: Annex Memorial Co
18. Funeral director: A Halstead
Address: 9 E Druid Hill Ave

19. March 27, 1946 (Date rec'd by registrar) Albert R. Swackhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27, 1946 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28, 1946 to March 27, 1946 and that I last saw him alive on March 27, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 months
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: I.B. Lyon M. D. ~~or other~~
Address: Henryton, Maryland Date signed: 3-27-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02535

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 month, 1 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 601 Conway Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME NATHANIEL SHAND

3.(b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife Mary Lee Shand
6.(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) July 7, 1910

8. AGE: Years	Months	Days	If less than one day
35	8	15	...hrs. ...min.

9. Birthplace Stoney Creek, Va.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Noah Shand
13. Birthplace Stoney Creek, Va.

MOTHER
14. Maiden name Unknown
15. Birthplace Stoney Crkke, Va.

16. Informant I. B. Lyon, M. D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26th 1946 (month) (day) (year)
Cemetery or crematory Mt Calvary Cemetery
Location Baltimore Md
18. Funeral director Elmer O Wilson
Address 1000 Brantley

19. 3/22 (Date rec'd by registrar) 1946 Albert R. Sanderson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1946, at 9.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21, 1946, to March 22, 1946
and that I last saw him alive on March 22, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE J. B. Lyon M. D. or other
Address Henryton, Md. Date signed 3/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

02536

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Mt. Airy Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Mt. Airy, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jeanette P. Simms.

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col.	sigle

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.): March 1, 1946

8. AGE:

Years	Months	Days	If less than one day
		4	hrs. ..... min.

9. Birthplace: Carroll Co. Maryland.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name: Lucille H. Simms
15. Birthplace: Maryland.

16. Informant: Lucille H. Simms

Address: Mt Airy Md.

17. (Burial, ~~cremation~~, or removal. Which?) Burial — Date thereof 3-6-46 (month) (day) (year)

Cemetery or ~~crematory~~: Mt. Zion

Location: near Mt. Airy. Carroll Co. Md.

18. Funeral director: E. M. Waltz

Address: New Windsor Md.

19. 3/5/46 19 ..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1946 19 ..... at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1946 19 to March 5, 1946 19 ..... and that I last saw her alive on March 4, 1946 19 .....

Immediate cause of death	DURATION
Atelectasis	4 da
Due to: Premature	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other

Address: Mt Airy, Md Date signed 3/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (486)

CERTIFICATE OF DEATH

02537

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No. E. Bishop (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eliza Jane Smith

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Lewis E. Smith

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Dec. 6 - 1866

8. AGE:

Years	Months	Days	If less than one day
79	3	16	....hrs. ....min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name David A Byers

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Sidney A Baust

15. Birthplace Md.

16. Informant Chas. Smith

Address E. Bishop St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 23 - 1946 (month) (day) (year)

Cemetery or crematory Meadow Branch Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 3/23 1946 (Date rec'd by registrar) L E Leasure Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1946 at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 - 1945, to Mar. 22 1946 and that I last saw her alive on Mar. 21 1946

Immediate cause of death	DURATION
Acute Cardiac Dilatation	3 hrs
Carcinoma of Uterus	18 Mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ....Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R Fonts M.D. M. D. or other

Address Westminster Md. Date signed 3-23-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02538

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yr., 3 mo., 25 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 yr., 3 mo., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME Henry Nicholas Spinken

3.(b) Social Security Number 230-05-4041

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Delphine Lovette
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1891

8. AGE: Years	Months	Days	If less than one day
54 (?)	6	10	hrs. min.

9. Birthplace: Wilmington, Delaware (Town, county, and state)
10. Usual occupation: painter (commercial)
11. Industry or business:

FATHER
12. Name: Frederick Spinken
13. Birthplace: Germany

MOTHER
14. Maiden name: Bertha Smith
15. Birthplace: Germany

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal? Which?) Date thereof: 3-26-46 (month) (day) (year)
Cemetery or crematory: Lombardy Cem.
Location: Wilmington, Del.

18. Funeral director: C. Harry Weer
Address: Sykesville, Md.

19. Mar. 24 1946 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1946, at 1:15p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to March 22 1946
and that I last saw him alive on March 22 1946

Immediate cause of death	DURATION
General paralysis of the insane	8 years
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 3-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02539

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 2 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Daisy Stephens

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
68 (?)			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Record of Springfield State Hosp.
Address:

17. Burial (Burial, cremation, or removal, Which?) Date thereof 3-12-46 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Mar. 12 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1946, at 11:20 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/7/ 1946, to 3/9/ 1946 and that I last saw her alive on 3/9/ 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9/45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Virginia Bevyn M.D. (M.D. or other)

Address: Sykesville, Maryland Date signed: 3/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02540

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P. George's
City or town: East Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Beacon Light Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HENRY THOMPSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Ada Thompson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25, 1890

8. AGE:	Years	Months	Days	If less than one day
	55	2	18	hrs. min.

9. Birthplace: Marshall, Va. (Town, county, and state)
10. Usual occupation: Laborer on state road
11. Industry or business

FATHER
12. Name: James Thompson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sarah Bridget
15. Birthplace: Virginia

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 2 1946 (month) (day) (year)
Cemetery or crematory: Methodish
Location: Bladensburg Md
18. Funeral director: F Casalis Sons
Address: Bladensburg Md

19. March 30, 46 (Date rec'd by registrar) 19 Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30, 1946 at 7:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1946 to March 30, 1946 and that I last saw him alive on March 30, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D. ~~or other~~
Address: Henryton, Md. Date signed: 3-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (96d)

CERTIFICATE OF DEATH

★ 02541 72 Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Silver Run (Westminster R.D.I)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Silver Run (Westminster R.D.I
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Peter Urias Utz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida (Marsh) Utz
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): August 9th. 1874

8. AGE: Years	Months	Days	If less than one day
71	7	13	..... hrs. ..... min.

9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business: Farm

FATHER
12. Name: Urias Utz
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Rebecca Stegner
15. Birthplace: Carroll Co. Md.

16. Informant: Lew Utz
Address: Westminster Md. R. D. I

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/46 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Silver Run Md.
18. Funeral director: F. M. Little & Son
Address: Littlestown, Pa. Reg. R.A.L.
19. Mar. 23rd 1946 (Date rec'd by registrar) Calvin T. Bankert Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: March 22 19 46 at 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March Feb. 22 19 44 to May 22 19 46
and that I last saw him alive on March 19 19 46

Immediate cause of death	DURATION
Myocardial degeneration	5+ months
Due to	
Due to	
Other conditions: Edema, Bronchitis (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reese Silkens M.D. M. D. or other
Address: Westminster Md Date signed: 3/23/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02542

Reg. Diat. No. 42

1. PLACE OF DEATH:

County Carroll

City or town Westminster R.I (Nr. Silver Run)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster R.I (Nr. Silver Run
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jacob Cleveland Wantz

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age ------ years

7. Birth date of deceased (mo., day, yr.) Sept. I5 I884

8. AGE: Years	Months	Days	If less than one day
6I	6	0	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business Farm

FATHER
12. Name Josiah Wantz
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Catherine Roser
15. Birthplace Carroll Co. Md.

16. Informant William H. Wantz

Address Westminster Md. R.D. I

17. Burial Date thereof 3/I7/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Piney Creek Brethern Cem.

Location Nr. Taneytown Carroll Co. Md.

18. Funeral director J. W. Little & Son

Address Littlestown, Pa. Pa. R.A.L.

19. Mar. 15th. 1946 Calvin Bankert
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A-

20. DATE OF DEATH March I5th. 1946, at I2:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st 1946 to March 15th 1946 and that I last saw h[illegible] alive on on about March 15th 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Stewart M. D. or other

Address Westminster Md. Date signed March 15 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02543

CERTIFICATE OF DEATH

Reg. Diat. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Finebro, md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State: Md. County: Carroll

City or town: Rural Finebro md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LORENA DOLL WILDASIN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colrd	Married

6.(b) Name of husband or wife: Daniel P Wildasin

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Aug. 30 1881

8. AGE: Years	Months	Days	If less than one day
64	6	27	hrs. min.

9. Birthplace: York Co Pa (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Doll

13. Birthplace: York Co. Pa.

MOTHER — 14. Maiden name: Anna Mary Mehrley

15. Birthplace: York Co. Pa.

16. Informant: Daniel Wildasin

Address: Finebro md RD

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/31/46 (month) (day) (year)

Cemetery or crematory: Stone Church

Location: Glenville. Pa.

18. Funeral director: H. Geible

Address: Glenville. Pa.

19. Mar. 28 1946 (Date rec'd by registrar) Mrs. W. R. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 27 1946, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-11 1946, to 3-26 1946

and that I last saw her alive on 3-26 1946

Immediate cause of death	DURATION
Influenzal Virus Pneumonia	3 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op. none

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis Schatenoff M.D. M. D. or other

Address: New Freedom, Pa. Date signed 3-28-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING